

CALIFORNIA WING – APPLICATION FOR CAP ACTIVITY

CAP ID NUMBER (6 DIGITS)		REGION	WING	GROUP	SQUADRON	CHARTER # CA-???	<input type="checkbox"/> CADET <input type="checkbox"/> SENIOR	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
NAME (LAST, FIRST MIDDLE INITIAL)					CAP GRADE	DATE JOINED CAP MMM-YYYY	HOME TELEPHONE (WITH AREA CODE)	
MAILING ADDRESS (NUMBER & STREET)					APARTMENT OR SPACE NUMBER		BUSINESS TELEPHONE (WITH AREA CODE)	
CITY					STATE	ZIP CODE	CELL PHONE NUMBER (WITH AREA CODE)	
DATE OF BIRTH (dd MMM yy)	HEIGHT	WEIGHT	SCHOOL GRADE (CADETS ONLY)	EMAIL ADDRESS				
ACTIVITY REQUESTED (ONE ACTIVITY PER APPLICATION, PLEASE)			LOCATION			DATE (dd-MMM-yy)		
RELIGIOUS PREFERENCE			ARE YOU INTERESTED IN ATTENDING RELIGIOUS SERVICES IF AVAILABLE? YES <input type="checkbox"/> NO <input type="checkbox"/>			Cadet Protection Training (18 AND OLDER ONLY) Completed <input type="checkbox"/> Will be completed by activity <input type="checkbox"/>		
TRANSPORTATION: ARRIVE BY: PRIVATE VEHICLE <input type="checkbox"/> CAP VAN <input type="checkbox"/> TRAIN <input type="checkbox"/> BUS <input type="checkbox"/> AIRPLANE <input type="checkbox"/>						SCHEDULE/FLIGHT/ARRIVAL LOCATION		
DRIVER'S NAME:								
TRANSPORTATION: RETURN BY: PRIVATE VEHICLE <input type="checkbox"/> CAP VAN <input type="checkbox"/> TRAIN <input type="checkbox"/> BUS <input type="checkbox"/> AIRPLANE <input type="checkbox"/>						SCHEDULE/FLIGHT/DEPARTURE LOCATION		
DRIVER'S NAME:								
I WOULD LIKE TO ATTEND THIS ACTIVITY AS A: <input type="checkbox"/> Student/Participant <input type="checkbox"/> Cadet Staff Member – POSITION REQUESTED : <input type="checkbox"/> Senior Staff Member – POSITION REQUESTED: _____						T-SHIRT SIZE (SOME ACTIVITIES MAY PROVIDE T-SHIRTS) S <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> XL <input type="checkbox"/> 2XL <input type="checkbox"/>		
Special Meals Required <i>(Special meals may not be able to be accommodated)</i> What kind?								
SENIORS ONLY - PARTICIPATION: Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Part-Time Dates:								
PAYMENT OF EVENT FEES: I have included payment of \$ _____ in the form of: Cash: <input type="checkbox"/> Check: <input type="checkbox"/> Money Order: <input type="checkbox"/> Credit Card: <input type="checkbox"/> (attach/enclose CAWGF14 or online receipt)							CAWG Use Only	
Comments:								
Emergency Contact During Activity – Parent, Guardian, or closest relative to be contacted in case of emergency				Daytime Phone – MUST be available during activity		Evening Phone – MUST be available during activity		

CAWGF150 (Version 1.03 – 08/08) Replaces CAWGF31 which is obsolete

mmp-ajg

NAME (LAST, FIRST MI)	<input type="checkbox"/> CADET <input type="checkbox"/> SENIOR	CAPID	ACTIVITY	DATE OF ACTIVITY
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RELEASE AGREEMENT

MEDICAL INFORMATION (FOUO) - TO BE COMPLETED BY ALL APPLICANTS

NAME OF PARTICIPANT (Last, First Middle Initial)		<input type="checkbox"/> CADET <input type="checkbox"/> SENIOR	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	CAPID
ACTIVITY	LOCATION		DATES	
DO YOU CURRENTLY USE ANY MEDICATION? (Including eye drops) <input type="checkbox"/> NO <input type="checkbox"/> YES (List any medication taken and the reason in the remarks section.)				
HAVE YOU BEEN INVOLVED IN AN ACCIDENT REQUIRING MEDICAL TREATMENT IN THE PAST FIVE YEARS? <input type="checkbox"/> NO <input type="checkbox"/> YES (Explain the extent of your injuries and treatment required in the remarks section.)				
MEDICAL TREATMENT WITHIN THE PAST FIVE YEARS OTHER THAN REGULAR OFFICE VISITS OR PHYSICALS? <input type="checkbox"/> NO <input type="checkbox"/> YES (Explain the extent of your injuries and treatment required in the remarks section.)				
HAVE YOU HAD OR HAVE NOW ANY OF THE FOLLOWING? (If yes is answered on any items, please explain why in the remarks section with dates and physician(s) consulted (if any). Items not specifically noted below having the potential to interfere with performance during the special activity or encampment should be documented in the remarks section.)				
1. Tuberculosis <input type="checkbox"/> N <input type="checkbox"/> Y	10. Knee trouble (locking, giving out, pain, etc.) <input type="checkbox"/> N <input type="checkbox"/> Y	19. Period of unconsciousness or concussion <input type="checkbox"/> N <input type="checkbox"/> Y		
2. Asthma or breathing problems related to exercise, weather, pollens, etc. <input type="checkbox"/> N <input type="checkbox"/> Y	11. Knee or foot surgery <input type="checkbox"/> N <input type="checkbox"/> Y	20. Heart trouble or murmur <input type="checkbox"/> N <input type="checkbox"/> Y		
3. Shortness of breath <input type="checkbox"/> N <input type="checkbox"/> Y	12. Any need to use corrective devices such as prosthetic devices, braces, back supports, lifts, etc.) <input type="checkbox"/> N <input type="checkbox"/> Y	21. Nervous trouble (anxiety or panics attacks) <input type="checkbox"/> N <input type="checkbox"/> Y		
4. Wheezing or problems with wheezing <input type="checkbox"/> N <input type="checkbox"/> Y	13. Stomach, liver, intestinal trouble, or ulcer <input type="checkbox"/> N <input type="checkbox"/> Y	22. Depression or excessive worry <input type="checkbox"/> N <input type="checkbox"/> Y		
5. Been prescribed or used an inhaler <input type="checkbox"/> N <input type="checkbox"/> Y	14. High or low blood sugar <input type="checkbox"/> N <input type="checkbox"/> Y	23. Inability to stand, sit, kneel, lie down, etc. <input type="checkbox"/> N <input type="checkbox"/> Y		
6. Ear, nose, or throat trouble <input type="checkbox"/> N <input type="checkbox"/> Y	15. Adverse reaction to serum, food, insect sting/bites, or medicine <input type="checkbox"/> N <input type="checkbox"/> Y	24. Any drug or narcotic habit <input type="checkbox"/> N <input type="checkbox"/> Y		
7. Painful shoulder, elbow, or wrist (pain, dislocation, etc.) <input type="checkbox"/> N <input type="checkbox"/> Y	16. Frequent or severe headaches <input type="checkbox"/> N <input type="checkbox"/> Y	25. Attempted suicide <input type="checkbox"/> N <input type="checkbox"/> Y		
8. Impaired use of arms, legs, hands, or feet <input type="checkbox"/> N <input type="checkbox"/> Y	17. Seizures or convulsions; epilepsy <input type="checkbox"/> N <input type="checkbox"/> Y	26. Severe menstrual cramps (<i>Females only</i>) <input type="checkbox"/> N <input type="checkbox"/> Y		
9. Chronic or recurring injuries <input type="checkbox"/> N <input type="checkbox"/> Y	18. Motion sickness <input type="checkbox"/> N <input type="checkbox"/> Y	27. Are you currently in good health <input type="checkbox"/> N <input type="checkbox"/> Y		
IMMUNIZATIONS		MEDIC ALERT® ID NUMBER (If worn):		
<input type="checkbox"/> Up-to-Date <input type="checkbox"/> Exceptions:				
FAMILY / PRIMARY PHYSICIAN	Address		Phone	
MEDICAL INSURANCE INFORMATION		INSTRUCTIONS FOR CAPF150-MED) Completed Medical Information Forms are For Official Use Only (FOUO). Information gathered in this form shall not be accessed by anyone without a need-to-know, such as: project officers, activity commanders, medical officers and physicians. The project officer/commander is responsible to properly protect this sensitive medical information.		
COMPANY:				
POLICY NUMBER:				
Emergency Contact During Activity – Parent, Guardian, or closest relative to be contacted in case of emergency	Daytime Phone – MUST be available during activity	Evening Phone – MUST be available during activity		
REMARKS (Please include any drug or food allergies and all prescription or OTC medication. Describe what the medication is treating and severity of food allergies, if any. This information is very important to treating physicians).				

